Rochester Rehabilitation

MENTAL HEALTH REFERRAL FORM

Date Completed: _____

❑ MH CENTER ❑ VENTURES PROS

INDIVIDUAL INFORMATION

Name:		**DOB:**		❑ **Male**	❑ **Female**
Address: _____		**Phone:** _____(H) _____ (C) **Email:**			
Ethnicity:	❑ **Caucasian**	❑ **African American**	❑ **Hispanic**	❑ **Asian**	❑ **Other (specify)**
Primary Language:	❑ **English**	❑ **Spanish**	❑ **ASL**	❑ **Other (specify)**	
Marital Status:		**Are you a Veteran?**			
Highest Level of Education Completed:	❑ **High School**	❑ **GED**	❑ **Some College**	❑ **Degree**	
Religion:					
Current Legal Status:	❑ **None**	❑ **Parole**	❑ **Probation**	❑ **Pending**	
Living Arrangement:					
Emergency Contact:		**Relationship:**		**Phone:**	
Have you ever been a client of Rochester Rehabilitation in the past: ❑ **Yes** ❑ **No. If yes, what program(s):** _____					
Do you have a family member or significant other receiving mental health services at Rochester Rehabilitation? ❑ **Yes** ❑ **No**					

INSURANCE INFORMATION

Social Security Number:			
Medicaid Number (sequence #):		**County of Responsibility:**	
Medicaid Option Plan: ❑ **Yes** ❑ **No**	**If Yes:** ❑ **Blue Choice Option** ❑ **MVP** ❑ **Fidelis**		
Medicare Number:	❑ **Medicare Part A**	❑ **Medicare Part B**	
Medicare Part D Number:	**Provider:**		
Other Insurance Provider:	**Other Provider Number:**		
Are you enrolled in any Medicaid Waiver Program? ❑ **Yes** ❑ **No** **If Yes, provide contact information:**			
Employment Status:	**Occupation:**		
Do you have a Medicaid spend-down: ❑ **Yes** ❑ **No** **If Yes, spend-down amount: $**			
Do you participate in Medicaid buy-in? ❑ **Yes** ❑ **No**			

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CURRENT SERVICE PROVIDERS			
	Name/Address	**Phone**	**Fax**
Primary Care Medical Provider			
Therapist			
Psychiatrist			
Case Manager			
Residential Contact			
Other Psychiatry Services			

PERSONAL GOAL INFORMATION

What are your life goals?

What barriers to those goals are you working to overcome?

What symptoms do you experience (check all that apply):

- ❑ Dangerous to self or others
- ❑ History of suicide, danger to self
- ❑ Self harm (self-injurious behaviors)
- ❑ Homicidal – danger to others
- ❑ Ritualistic behavior
- ❑ Depression/Mania
- ❑ Anxiety/Agitation
- ❑ Paranoia
- ❑ Hallucinations
- ❑ Severe mood swings
- ❑ Confusion/Disorientation
- ❑ Poor judgment/impulsivity
- ❑ Memory loss
- ❑ Socially withdrawn
- ❑ Sexual inappropriateness
- ❑ Non-compliant with medications
- ❑ Problems with eating
- ❑ Problems with sleeping
- ❑ Racing thoughts
- ❑ Other:

Describe your ability to participate, interact, and accept responsibility in group situations:

PSYCHIATRIC DIAGNOSIS

Axis I:_____ **Axis II:** _____

Axis III: _____ **Axis IV:** _____

Axis V: _____

Previous psychiatric hospitalizations: **Admission/Discharge dates:**

_____ _____

_____ _____

Previous Outpatient programs: **Admission/Discharge dates:**

_____ _____

_____ _____

Current Medications: _____

Chronic Medical Conditions: _____

Special Needs: **Allergies** (Foods or Medications)**:**

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DRUG AND ALCOHOL SCREENING	
Please give a brief overview of your experience with drugs and alcohol: _____	
Age of first use: _____	**Substance(s) used:** _____
Date of last use:	**Substance(s) used:**
Have you ever received treatment for addiction and if so, please give provider and dates of service: _____	
Are you currently receiving substance abuse treatment or involved in self-help groups? If yes, please specify: _____	

REQUIRED SERVICES	
What mental health services might be helpful to you? Please check all that apply:	
❑	MH Center only: individual counseling and psychotherapy, group therapy, and medication evaluation/consultation for adults that experience barriers to functioning in their everyday lives.
❑	PROS Continued Recovery Support (CRS): classes, groups, and skills development opportunities to improve self care, life management, community living, social and work readiness skills.
❑	PROS Clinical Treatment: working with a prescriber, nurse, and therapist on medication and symptom management. (Must receive other PROS services as well).
❑	PROS Intensive Rehabilitation (IR): short term service to work intensely on a rehabilitation goal such as achieving a life role or intensive symptom management to avoid losing a life role.
❑	PROS Ongoing Rehabilitation Support (ORS): vocational support for individual currently employed at least 10 hours per week.

Please mail or fax the information requested below along with the Referral Form to:

Mental Health Center Intake Coordinator
Rochester Rehabilitation
1000 Elmwood Avenue | Rochester NY 14620
Phone: **585.271.2520 ext. 1594** | Fax: **585.286.9236**

OR

Ventures PROS Intake Coordinator
Rochester Rehabilitation – Ventures PROS
975 Elmwood Avenue | Rochester NY 14620
Phone: **585.256.3430 ext. 1017** | Fax: **585.935.7861**

Referring Individual (please print): _____ **Signature:** _____

Referring Agency: _____

Phone: _____ **Email:** _____

Please include:

- ❑ Clinical summary or current psychosocial history
- ❑ Current treatment plan (if applicable)
- ❑ Copies of insurance cards
- ❑ Current medication log (if applicable)
- ❑ Other psychiatric services client receives (for example, outpatient group)